

HEALTH INSURANCE STUDIES: CONTRACT RESEARCH SERIES

AN EVALUATION OF SWING-BED EXPERIMENTS TO PROVIDE LONG-TERM CARE IN RURAL HOSPITALS

VOLUME I

FINAL SUMMARY REPORT

MARCH 1980

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ABSTRACT

The findings and implications of the evaluation of the swing-bed experiments in Texas, Iowa, and South Dakota are summarized in this report. Under these experiments, 82 rural hospitals were permitted to provide long-term care in hospital beds normally restricted to the provision of acute care. Two key features characterized the experiments: (1) a waiver of certain regulatory standards normally required of long-term care providers and (2) a reimbursement approach based on incremental cost.

An overview of the swing-bed approach is provided in this report along with a presentation of the major findings and policy implications of each component of the evaluation. Recommendations on the implementation of a nationwide swing-bed program are also included.

The major conclusions of the evaluation are:

- (1) It is appropriate to implement a national swing-bed program in rural areas.
- (2) Such a program would be of benefit to rural communities in terms of meeting both long-term care and acute care needs.
- (3) Assuming reimbursement is flexible and based upon the concept of incremental cost of care, the swing-bed approach is a cost-effective means of providing long-term care.
- (4) A number of financing, quality assurance, and regulatory issues must be considered in structuring a national swing-bed program. Recommendations on these topics are provided in this report.

The findings presented here are based primarily on the swing-bed experiments in Texas, Iowa, and South Dakota. The policy implications, however, draw upon several years' experience in evaluating not only these experiments, but also the swing-bed project in Utah.

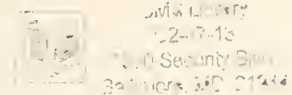
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VOLUME I: FINAL SUMMARY REPORT

by

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March 1980

This report is made pursuant to contract #SSA-600-77-0051 between the Health Care Financing Administration, Department of Health, Education, and Welfare, and the Center for Health Services Research, University of Colorado Health Sciences Center. The amount charged to the Department of Health, Education, and Welfare for the work resulting in this report (inclusive of amounts charged for prior reports, research design documents, and data collection activities) is \$543,591. The person employed by the contractor with managerial and professional responsibility for such work and for the content of the report is Dr. Peter W. Shaughnessy.

The Project Officer for this contract is Mr. Spike Duzor, a staff member within the Office of Research, Demonstrations, and Statistics. The views and opinions expressed in this report are the contractor's and no endorsement by the Health Care Financing Administration or the Department of Health, Education, and Welfare is intended or should be inferred.

In Memory of James Baker

ACKNOWLEDGEMENTS

This report is dedicated to the memory of Mr. James Baker. Jim was the original project officer on this study and was highly instrumental in facilitating several activities of the swing-bed evaluation in its early stages. For the entire project staff, his untimely death resulted in the loss of a friend, a fine individual, and a competent professional colleague whose career had just begun. While we wish we could offer more than an evaluation report series, it is the best means available to us in a professional forum to express our genuine appreciation for the contribution which Jim made and our sincere regrets that he is no longer with us.

Several individuals in South Dakota, including Ervin Schumacher, Arthur Fecht, and Dennis Callies, have assisted throughout the evaluation in a variety of ways. These have included the provision and acquisition of data, enlisting the cooperation of a number of agencies, and conceptual discussions on the swing-bed approach. In Iowa, Robert DeHoet, Lee Campbell, Richard Heger, Kent Walker, and Larry Breeding provided similar assistance. In Texas, Phil Cartwright, Deborah Novak, Charles Richie, Sam Edwards, Sidney Rich, Dorothy Crawford, and William Medford have assisted in a number of conceptual, logistical, and empirical aspects of this study. Several individuals from Utah have also contributed their time and knowledge to the study. These include Bruce Walter, Donald West, and Neil Miller.

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As principal investigator, I would like to express my deep appreciation to the evaluation project staff, especially Eileen Tynan, David Landes, and Charles Huggs, who have carried the major responsibilities of the

entire project on a day-to-day basis. Further, I wish to acknowledge the contributions of Daniel Holub and Linda Breed, whose work in the financial and quality components of the study, and general involvement in other facets of the evaluation, has been considerable. The depth and comprehensiveness of the results of the quality component were substantially enhanced by the work of Arlene Woodson and Elizabeth Lutz in the areas of criteria set development, data instrument design, and data collection. Inez Yslas has contributed greatly through her efforts in the data processing and empirical components of the study. Pamela Friedman provided a great deal of assistance in the coding of Medicare claims data and made a significant contribution to the editorial work on the final report. Jot Hollenbeck's assistance in the statistical analysis and computer processing aspects of the final report was also helpful. As project secretaries, Charlotte Gordy, Phyllis Hunter, and Jennifer Mieger have had a wide range of administrative and clerical responsibilities, carrying them out most adeptly. A number of other Center staff members have assisted in a variety of ways. These include Robert Schlenker, Bettina Kurowski, Ann Jones, Selma Gaines, Kristin Paulson, Ann Trickler, Daniel Jackson, Nancy Shanks, Sharon Becker, and Jean Bell.

Peter W. Shaughnessy

PREFACE

The report series on the evaluation of the swing-bed experiments in Utah, Texas, Iowa, and South Dakota consists of several documents, all of which are listed in Appendix A of this report. The present report is one of two volumes which present final results of the evaluation of three swing-bed projects: the two Reducing Acute Care Costs (RACC) experiments in Texas and western Iowa/South Dakota, and the Iowa Swing Bed Project (ISBP) in central Iowa. The major findings and implications of the evaluation of these projects are summarized in this report. Volume II is intended for a technical audience and contains, in addition to the findings and implications presented here, a full discussion of the methodological aspects of the evaluation. A history of the swing-bed experiments is also included in Volume II.

An overview of the swing-bed approach and related policy issues is presented in Chapter I. The second chapter contains a summary of the overall findings of each component of the evaluation. Chapter III presents the conclusions and policy-specific recommendations of the evaluation on the implementation of a nationwide swing-bed program. Discussion of the methodological aspects of the evaluation, including data sources, the conceptual approach, and statistical techniques, is deliberately minimized in this report. The reader is referred to Volume II for details in these areas.

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CHAPTER I

INTRODUCTION

A. RATIONALE FOR SWING-BED CARE IN RURAL COMMUNITIES

Despite the progress which has been made in reducing some of the discrepancies between rural and urban communities in terms of access to health care services, health care in many rural areas is still characterized by a shortage of qualified personnel and a lack of comprehensive medical services. Consequently, it is not unusual for rural residents to travel great distances to obtain health care. Such access problems can, on many occasions, be more than simply a matter of inconvenience. Accessible emergency care in an acute care hospital may represent the difference between long-term disability and complete recovery, high cost and low cost of care, or even life and death under certain circumstances. In the area of long-term care, the lack of adequate nursing home care in a rural community may result in the placement of long-term care patients in distant nursing homes, thus hindering the ability of family and friends to visit and limiting the quality of the psychosocial environment. Given the long stays usually associated with nursing home care, this has the potential to impede the delivery of adequate long-term care to residents of rural communities.

To assist in meeting the medical needs of rural residents, the Hill-Burton program was initiated in the 1940s as a means of providing federal funds for the construction of rural hospitals. Although the program provides the potential for attracting physicians and developing centers for comprehensive health services, the demand for acute care is uneven in many rural communities. Small rural hospitals usually lack the financial advantages which can accrue from economies of scale and shared service arrangements more commonplace in metropolitan areas; and thus, while hospitals have been constructed in many rural areas, such facilities are often financially unstable and faced with possible closure. Medicare- and Medicaid-certified rural nursing homes, in contrast, are often characterized by high occupancy rates and patient waiting lists.

In response to this dilemma of an excess of hospital beds and a scarcity of certified nursing home beds in rural communities, the swing-bed concept was proposed. The term "swing-bed" refers to a hospital bed which can be used to provide care to either acute or long-term care patients. The ability to use beds in this manner allows an acute care hospital to provide care to patients who might more traditionally receive care in a nursing home.¹

¹Long-term care need not be provided only in an institutional environment such as a hospital or nursing home. In this report, however, the primary emphasis is on the institutional setting.

In 1973, the Department of Health, Education, and Welfare (DHEW) funded an experimental program in Utah to determine whether the use of hospital swing beds would assist in satisfying the demand for long-term care in rural communities and improve the stability of rural hospitals. In 1976 and 1977, three additional swing-bed experiments were initiated in Texas, South Dakota, and Iowa to allow further empirical investigation of the advantages and disadvantages of providing long-term care in hospital swing beds in rural communities.

The swing-bed experiments made several assumptions about the health care delivery system in rural areas:

- (1) An unmet demand for institutional long-term care exists in many communities;
- (2) Surplus staff capacity is present in a number of rural, under-occupied hospitals;
- (3) Provision of adequate long-term care may be possible in a hospital setting if staff members are sufficiently well-acquainted with the administrative and patient-level aspects of providing such care;²
- (4) The provision of long-term care in existing rural hospitals is potentially more cost-effective than other alternatives in meeting the demand for institutional long-term care;
- (5) There are advantages which would accrue to long-term care patients and their families and friends from the convenience associated with visiting in their own communities instead of more distant locations; and,
- (6) There are substantial benefits to rural areas in maintaining community hospitals: namely, the continued availability of acute care, the diversification of the service program of rural hospitals, and the maintenance of such hospitals as vital parts of the economies of rural communities.³

²The traditional medical model on which hospital care is based often fails to emphasize the importance of the psychosocial and functional problems of the chronically ill. Hence, genuine concern existed from the outset that hospital-based long-term care might be inadequate in these areas.

³The wholesale closure of 20% of all rural hospitals in 1977 would have resulted in less than a 3.5% reduction in total hospital costs in the U.S., a percentage far below the annual inflation rate for hospital costs in this country. The true cost reduction would very likely have been less than 2.5% since the 3.5% figure assumes no transfer cost, which is highly unlikely.

B. REGULATORY HISTORY

In view of the fact that the experimental swing-bed approach represents a partial return to an earlier health care practice of hospitals caring for both acute and long-term care patients, it is appropriate to examine why the practice was discontinued. With the inception of Medicare and Medicaid, it was required that if a hospital was to be reimbursed for long-term care by Medicare or Medicaid, it must first be certified by DHEW to provide that care.⁴ Certification covers two levels of long-term care, skilled and intermediate, which are discussed below. Regulatory requirements also called for a hospital to provide a physically distinct part (such as a building, wing, or corridor) exclusively for the provision of long-term care.

Certification conditions require that long-term care facilities, including hospital distinct-part facilities, provide such specialized services as physical therapy, social services, and patient activities. These are services in addition to those required for the hospital to receive Medicare and Medicaid reimbursement for acute care and are intended to establish minimum standards for the quality of care provided to Medicare and Medicaid patients. Despite the fact that hospitals automatically satisfy several long-term care certification standards by virtue of acute care certification, there are certain long-term care certification criteria which hospitals do not routinely satisfy. In order to meet such criteria, it would be necessary for many hospitals to incur additional costs, a requirement which can act as a disincentive to provide long-term care.

Since long-term care is generally less expensive than acute care, a facility must have a mechanism for appropriately reporting its long-term care costs. Specifically, if a hospital were not to maintain a distinct part, it would be difficult to separate long-term care costs from acute care costs, and for third-party payers to properly reimburse for their fair share of hospital costs. Establishment of a distinct part exclusively for long-term care, however, limited the capability of a hospital to use beds in the most efficient and cost-effective manner. As a result of reimbursement policy and certification procedures, the typical circumstances under which hospitals were able to provide both acute and long-term care in the same facility were therefore changed significantly with the advent of Medicare and Medicaid.

⁴The three major types of long-term care: skilled nursing, intermediate, and personal care, are described and defined in greater detail in Section C. Medicare certifies and reimburses only for skilled nursing care, whereas Medicaid certification applies to both skilled nursing and intermediate care facilities. The certification criteria for Medicare and Medicaid are termed "conditions of participation."

Due in part to regulatory stringency and the administrative inconvenience associated with Medicare reimbursement, the number of beds in Medicare-certified free-standing skilled nursing homes and hospital-based distinct parts decreased during the late Sixties and early Seventies, although this downward trend has shown a reversal in recent years. Between 1968 and 1975, the number of Medicare-certified skilled nursing care beds decreased from 337,000 to 287,000 nationwide; but, by 1977, the total had increased to 381,000 beds.⁵ Rural communities in particular have a shortage of such beds. For example, in 1974, just prior to implementation of the swing-bed experiments in South Dakota, Iowa, and Texas, rural counties in these states averaged five, three, and one Medicare-certified skilled nursing care beds per 1,000 Medicare enrollees, respectively. The comparable figure for the entire United States was 15 certified beds per 1,000 Medicare enrollees.

A provision currently exists in Medicare policy to handle situations where long-term care beds are lacking. It allows hospitals to provide long-term care at acute care rates if it can be documented that a nursing home bed is not available for the patient.⁶ Patient days of care allowed under this provision are sometimes referred to as "administratively necessary days". A similar concept for Medicaid, termed the "holding bed", has been advocated in various states. Under this approach, hospitals are able to hold a Medicaid patient in acute care status until a nursing home bed becomes available. These options entail higher reimbursement outlays for third party payers, however, and are not considered appropriate for widespread use.

C. LONG-TERM CARE

The difference between acute care and long-term care naturally arises in a discussion of swing-bed care. As opposed to acute care patients, whose medical problems usually require short-term, high intensity treatment, long-term care patients are often chronically ill and/or disabled. Included in this category are patients with chronic physical and/or mental disease, or mental retardation. Those most prone to chronic disease, and thus most often requiring long-term care, are the elderly. While the needs of long-term care patients are usually not as medically intense as the needs of acute care patients, one of the challenges to the adequate provision of long-term care is the diversity of functional, psychosocial, and medical needs of the long-term care patient. "Quality of life" is a more appropriate goal in the provision of long-term care as opposed to acute care, due to the range of patient needs and the

⁵U.S. Department of Health, Education, and Welfare, Social Security Administration, Health Insurance Statistics, HI-75, 2 February 1977.

⁶Health Care Financing Administration, Part A Intermediary Manual, Part 3--Claims Process (HIM-13-3), Section 3421.2(A). Reprinted September 1977.

greater lengths of stay typically associated with long-term care.

There are three generally recognized levels of long-term care:

- (1) The skilled nursing care patient is one whose acute care needs have been met but who still requires extended nursing care under the supervision of both a physician and registered nursing personnel. A Medicare/Medicaid-certified skilled nursing facility must have a transfer agreement with an acute care hospital to promptly provide acute care services when necessary.⁷ Almost all skilled nursing care is paid for by Medicare, Medicaid or private payers (primarily patients themselves).⁸
- (2) Intermediate care patients generally require supportive nursing care which can often be provided by a licensed practical nurse rather than a registered nurse. Care at the intermediate level is beyond that available at boarding homes and, as a practical matter, is usually available only through institutional facilities. Medicaid and private payers (primarily patients themselves) pay for intermediate care.
- (3) Personal care normally refers to residential care which is essentially custodial in nature and is the primary function of boarding and rest homes. Neither Medicare nor Medicaid reimburse for personal care and it is almost exclusively paid for on a private pay basis.

Some state Medicaid programs have more refined long-term care classification schemes than that given above. Also different patient care practices and reimbursement rates are generally associated with the various levels of long-term care. Related to patient classification is the need for an effective and efficient utilization review system for patient admission, placement, and length of stay, a need which has existed for some time in acute care and is now beginning to increase in significance in long-term care settings.

D. POLICY ISSUES

The swing-bed approach should be considered in the context of several major health care issues. A brief summary of the primary policy issues related to swing-bed care is provided below.

⁷This transfer agreement requirement supports the contention that skilled nursing facilities should ideally be located near acute care hospitals, a potential difficulty in rural communities.

⁸Unlike acute and ambulatory care, which involve a large number of commercial insurers, only a few commercial insurers cover, on a very limited basis, long-term care.

1. Finance/Reimbursement

It is essential to develop an appropriate mechanism for financing long-term care provided in hospital swing beds. The method of paying for such care, the manner in which it meshes with current reimbursement policy, and the financial incentives it presents for hospital providers of long-term care are likely to be strong determinants of the success of a swing-bed program.

2. Demand for Long-Term Care

The appropriateness of swing-bed care should be considered in view of a presently unmet and still growing demand for long-term care services in many communities. While outpatient and home health care as alternatives to institutional care are receiving more attention nationally, it appears important to move forward in the institutional area in view of the apparent need for such care in many rural communities, although outpatient or home health care may be preferable for at least some rural patients.

3. Hospital Diversification and Rural Health Care

The swing-bed approach may be viewed as a potential means of financially stabilizing rural hospitals through diversification of service mix. To the extent that this approach increases rural hospital diversification and financial stability, it also serves to meet needs other than those related directly to long-term care. Specifically, it increases the likelihood of maintaining the rural hospital as a center for health services, a point of access to acute and emergency care, and as a means of attracting needed health care professionals. Further, activities directed toward the stabilization of the rural hospital can be regarded as an effort to maintain a significant element of the economy in many rural communities.

4. Regulatory Flexibility

Various facets of swing-bed care test the adaptiveness and flexibility of the health care regulatory system. Issues of certificate of need, nursing home licensure for hospitals, professional licensure for hospital administrators (nursing home administrators must be licensed in nearly all states), the adaptation of reimbursement policy to incorporate swing-bed reimbursement, and the manner in which to apportion swing beds between acute care and long-term care for planning purposes are illustrations of the challenges which a health care innovation such as the swing-bed approach presents to the regulatory system.

5. Cost Containment

Under the assumption that it is possible to take advantage of existing hospital capacity to provide long-term care, it is reasonable to expect that the unit cost (the cost per day) of such care would be

less than that associated with building new nursing homes. However, it can also be assumed that current health care costs would increase slightly since an unmet demand appears to exist for long-term care in many rural areas. Thus, if this demand is to be met, total health care costs are likely to rise despite the fact that the swing-bed program might be the most cost-effective means to meet the demand.⁹

6. Quality Assurance/Utilization Review

The increasing trend toward quality assurance and utilization review in long-term care also affects care provided in swing beds. In fact, there is reason to be concerned that hospitals, many of which are inexperienced in addressing the broad spectrum of psychosocial and functional needs of long-term care patients, may not be as qualified as some types of nursing homes to provide such care. Consequently, development of quality assessment, quality assurance, and utilization review programs for long-term care provided in swing beds is important and should not be overlooked.

7. Eligibility Criteria

If a swing-bed program were to be implemented nationally, a major decision would focus on which hospitals would be eligible. In particular, decisions would have to be made on whether eligibility criteria should be specified in terms of hospital occupancy rates, number of beds, geographic location (rural versus urban), availability of certified nursing home beds in the community, and, in general, which criteria should apply in the certificate of need process.

The final chapter presents implications and suggestions which deal with primary features of the above policy issues.

⁹Although, results of the financial component of the evaluation indicate that the total increase in hospital care costs is likely to be less than 0.05%.

CHAPTER II

EVALUATION FINDINGS

A. EXPERIMENTAL SETTINGS

As indicated in the preceding chapter, four experiments have been funded by DHEW in order to assess the efficacy of the swing-bed approach in rural areas. The Utah Cost Improvement Project (UCIP), the two Reducing Acute Care Costs (RACC) experiments in Texas and western Iowa/South Dakota, and the Iowa Swing Bed Project (ISBP) in central Iowa permitted rural hospitals in a number of communities to provide long-term care without meeting all of the conditions of participation normally required for reimbursement for the provision of long-term care to Medicare and Medicaid patients. These certification requirements, as indicated earlier, have restricted the availability of long-term care beds in rural areas. Consequently, this waiver constituted one of the primary features of the experiments. The experiments differed in terms of starting dates, the number of hospitals participating, and administering agencies (at this writing, the four experiments remain ongoing, but are scheduled to terminate concurrently with the adjournment of the 96th Session of the United States Congress, on or about January 1, 1981).

- (1) The Utah experiment began in 1973, with a total of 25 hospitals eventually participating. The Utah State Division of Health administered the program.
- (2) The Texas experiment began in 1976, with 39 hospitals initially participating; the Texas Hospital Association was the administering agency.
- (3) The western Iowa/South Dakota experiment began in 1976 with 22 participating hospitals, and was administered by Blue Cross of Western Iowa and South Dakota.
- (4) The central Iowa experiment began in 1977, with 22 participating hospitals, and was administered by Blue Cross of Iowa.

This report summarizes the final results of the RACC experiments in Texas and western Iowa/South Dakota, and the ISBP experiment (termed the "central Iowa" project in this report). The Utah findings have been presented in earlier publications (see Shaughnessy 1978a and 1978b). Mention is made here of the UCIP experience as appropriate.

In addition to the waiver of the conditions of participation, an important feature of the swing-bed experiments has been the reimbursement procedures followed. While more details are provided in Volume II, it is useful to summarize the reimbursement procedures here, since they are pertinent to a general understanding of the overall study conclusions.

Medicare reimbursement for routine long-term care in certified skilled nursing facilities or hospital-based distinct-part facilities is based on the cost to the institution providing that care.¹ However, under the experiments, participating hospitals were not reimbursed on a cost basis; rather, reimbursement consisted of a per diem payment (uniform within each experiment) for skilled nursing care and an incentive payment intended to encourage hospital participation in the swing-bed program. Reimbursement for ancillary long-term care was handled in accord with the normal Medicare procedure for acute care.² The ISBP experiment differed from the RACC experiments in that no incentive was included in the reimbursement formula, nor was the per diem rate calculated in the same manner.

Medicaid and private pay patients also received long-term care in some participating hospitals, although Medicaid's participation in the Medicare experiments did not begin until well after their implementation. Medicaid reimbursement consisted of a per diem payment for skilled care in Texas and separate per diem payments for skilled and intermediate care in South Dakota. Unlike Medicare, however, Medicaid reimbursement did not include an incentive payment. Ancillary reimbursement was handled in accord with standard Medicaid procedure. In Iowa, Medicaid participated only to the extent of paying coinsurance for dual Medicare/Medicaid beneficiaries. Private pay patients were generally charged at the per diem rates used by Medicare and Medicaid and were billed for ancillary services on a fee-for-service basis.

In the final Medicare settlement, hospital long-term routine care revenues from all sources were offset against total routine care costs, thus reducing the Medicare allowable routine cost and cost settlement (hence, the experimental name "Reducing Acute Care Costs"). The RACC incentive payment, in turn, represented 50% of this "savings", or reduction in Medicare allowable acute care cost, attributable to the provision of long-term care. An incentive was also included in the reimbursement scheme employed in the original swing-bed experiment in Utah, although the formula for the calculation of the incentive was somewhat different from that employed in the RACC experiments.

B. EVALUATION METHODOLOGY

The primary aim of the evaluation has been to provide information on the overall functioning and strengths and weaknesses of the swing-bed approach,

¹Routine care refers to those services which consist of basic room and board, nursing, and similar services which are routinely provided to all inpatients.

²Ancillary care refers to diagnostic, laboratory, pharmacy, and related services usually given on a more discretionary basis in accord with each patient's individual needs.

with a view toward facilitating decisions on more widespread implementation of swing-bed care. The remainder of this section provides a brief overview of the evaluation, which is organized in five components: organization, utilization, quality, finance, and policy. The purpose of each component is summarized below, along with the data sources used. Other information on specific technical methods, variable definitions, samples, years of data analyzed, etc., is presented in Volume II.

1. Organization

Purpose: The purpose of the organizational component is to determine whether and how a national swing-bed program should be implemented from the perspective of acceptance by hospital staff and nursing home administrators. Facility and project characteristics are related to acceptance of the swing-bed approach, benefits and problems with providing long-term care in acute care hospitals are examined, and suggestions made by swing-bed hospital and nursing home administrators for implementation of a national swing-bed program are considered.

Data: The major data sources were surveys of swing-bed hospital administrators, directors of nursing, chiefs of staff, staff physicians, and nursing home administrators. In the evaluation of the operation of the swing-bed experiments, the primary focus was on the staffs of participating hospitals. In the analysis dealing with implementation of a national swing-bed program, however, emphasis was placed on information obtained from nursing home as well as hospital staff members.

2. Utilization

Purpose: The utilization component is designed to describe the acute and long-term care utilization patterns associated with the experimental swing-bed programs. Specifically, it is intended to assess the influence of the availability of swing-bed care on acute care length of stay and occupancy rate in swing-bed hospitals, and on nursing home utilization by residents of swing-bed communities. Also included is a prediction of utilization patterns in the event of national implementation of a swing-bed program.

Data: The primary data sources used were Medicare Cost Reports, project logs completed by the hospitals and monitored by the state level administering agencies, Medicare claim forms, and information obtained from state health departments, Medicaid programs, and administering agencies.

3. Quality of Care

Purpose: The quality component of the evaluation is intended to assess the quality of long-term care provided by the experimental swing-bed hospitals and to compare the quality provided by Medicare- and Medicaid-certified skilled nursing facilities. Thirty swing-bed hospitals and 15 comparison nursing homes in rural communities in

Texas, Iowa, and South Dakota were visited in order to obtain information on the quality of care provided. The quality component focuses on services provided to long-term care patients in the experimental hospitals and comparison nursing homes, rather than changes in patient status over time. It also includes an analysis of case mix differences between swing-bed and comparison nursing home patients.

Data: Information was collected on a patient-by-patient basis by an evaluation staff nurse experienced in long-term care. In sum, data on the quality of care provided was gathered on 6,859 occasions of service, 597 patient problems, and 158 patients in the 45 facilities. A multidisciplinary panel of experts in long-term care assisted in the development of explicit criteria which enumerate the services patients with specific types of long-term care problems should receive. The criteria were built on and incorporated the previous work of other long-term care providers and researchers. Data were gathered for individual patients and separate quality measures computed at the levels of services provided, patient problems, patients, and facilities for hospitals and nursing homes.

4. Finance

Purpose: The primary objective of the financial evaluation is to assess the cost, both full and incremental, of providing long-term care in swing-bed hospitals.³ It is also concerned with the impact of the experiments on the financial position of the participating hospitals. Reimbursement procedures and problems have been monitored throughout the experiments. As part of this effort, a conference which included participants experienced with swing-bed reimbursement, was held in the latter stages of the evaluation. The purpose of the conference was to obtain suggestions on how to structure reimbursement policy for swing-bed care, taking issues such as incremental cost, incentive payments, and payer mix into consideration.

Data: Medicare Cost Report and claims data, and supplemental cost and utilization information provided by both individual hospitals and the agencies administering the experiments, constituted the primary data bases analyzed in the financial component of the study. This study components involved assessing the cost of providing long-term care in swing-bed hospitals with a practical approach to reimbursement in mind. Different allocation schemes and incremental cost methodologies were employed as part of this component of the evaluation. Costs were examined on an individual cost center basis, with an effort to separate

³In this context, incremental cost refers to the "add-on" cost of providing long-term care in a facility which already exists to provide acute care. In contrast, the full cost of long-term care in a swing-bed hospital refers to the cost which would be calculated by appropriately allocating all components of hospital cost to long-term care. Thus, full cost is based on the assumption that the hospital exists to provide both acute and long-term care, and that capital costs, etc., should be allocated to both acute and long-term care.

variable costs (i.e., those which vary solely as a function of utilization) from fixed costs (such as capital costs).

5. Policy

Purpose: The objective of the policy component is to direct the analytic procedures and empirical findings of the overall evaluation toward policy-relevant conclusions. This component, therefore, presents policy conclusions through an integration of the findings and implications of the four components described above. Topics covered in these components such as cost-effectiveness, reimbursement policy, regulatory adaptation, interpretation of utilization and cost projections in the context of a national program, state level considerations, etc., all pertain to the policy component. While findings and implications are presented separately in each of the other components, the policy component synthesizes the overall study implications according to regulatory and health care topic areas which provide a summary of the conclusions from a policy perspective.

C. RESULTS

This section summarizes the major findings of the evaluation of the RACC and ISBP experiments. It should be emphasized again that the results of this evaluation pertain only to rural hospitals. Findings are presented below for the organization, utilization, quality, and finance components of the evaluation with very little interpretation or policy discussion. The reader is referred to Volume II for more detail on the conceptual and analytic approaches taken, descriptive data, background information, tabular material, results of statistical tests, and methodology employed to derive the findings presented here. Chapter III of this report deals with the policy implications of the findings and, therefore, presents the overall policy conclusions of the evaluation.

The 83 hospitals which formally agreed to participate in the experimental programs (39 from Texas in 1976, 22 from western Iowa/South Dakota in 1976, and 22 from central Iowa in 1977) ranged in size from 15 beds to 94 beds with an average of 37 beds per hospital in 1975.⁴ The average acute care occupancy rate in 1975 was 45.1%, ranging from 19.4% to 80.0% across the 83 participating hospitals.

1. Organization

- (1) The most frequent reasons given by hospital administrators for joining the swing-bed project, each of which was mentioned by

⁴Twenty-two hospitals from western Iowa/South Dakota entered the project, but one hospital in South Dakota closed due to the loss of its only physician. Therefore, it was excluded from the analyses and subsequent references in this report are to 82 study hospitals.

over 90% of the hospital administrators in the experimental programs, were to increase hospital occupancy, meet a need for long-term care in the communities, and use hospital space more efficiently. Over 80% joined in order to increase staff efficiency and slightly less than 70% joined in order to increase revenue.

- (2) Prior to the swing-bed experiments, approximately 21% of the participating hospitals had provided long-term care in a distinct part, 30% had provided long-term care under the Medicare special provision (discussed in Chapter I), and 30% had provided long-term care in acute care beds for private pay patients. More of the hospitals in Iowa and South Dakota than in Texas had operated a distinct part or provided long-term care under the Medicare special provision.
- (3) More hospital administrators (77.8%) and directors of nursing (55.6%) attended orientation by the administering agencies than chiefs of staff (24.4%) and staff physicians (30.4%). Approximately 90% of the participating hospitals received information on admission procedures, completion of monthly utilization reports, and filing of Medicare claims. The proportions of Texas hospital staff attending orientation were substantially lower than the proportions of Iowa and South Dakota hospital staff attending orientation. Fewer Texas hospitals received information on admission procedures, but there were no significant differences across projects in the proportion of hospitals receiving information on completion of monthly utilization reports or filing of Medicare claims.
- (4) The long-term care services most frequently available in the participating hospitals were physical therapy and social services, available in 53.1% and 35.8% of the hospitals, respectively. There were significant differences across projects for all five key long-term care services surveyed (physical therapy, speech therapy, occupational therapy, social services, and patient activities), with a larger proportion of central Iowa hospitals providing each of the five services.
- (5) Comparisons across projects on nurse staffing indicate that Texas hospitals had fewer registered nurses and more licensed practical nurses than hospitals in Iowa and South Dakota. More of the hospitals in western Iowa/South Dakota had nurses with training in rehabilitative nursing, but more Texas and central Iowa hospitals had nurses who received inservice training from the administering agencies.
- (6) Acceptance of the swing-bed experiment was relatively high for all four types of hospital staff surveyed. Over 70% of the hospital administrators and chiefs of staff, and over 80% of the directors of nursing and staff physicians who responded to the surveys wanted the experiment continued. Comparisons across

projects indicate that the central Iowa project had the highest level of acceptance among hospital staff, closely followed by the western Iowa/South Dakota project. These differences in hospital staff acceptance were related to several project characteristics. First, more hospital administrators from Iowa and South Dakota joined the experiment in order to meet a need for long-term care in their community. Second, more hospitals in these two projects had previously provided long-term care in either a distinct part or under the Medicare special provision. Third, hospital staff attendance at orientation was higher in these two projects. Fourth, hospitals in these two projects employed more registered nurses and fewer licensed practical nurses than Texas hospitals. Fifth, as indicated in (4) above, central Iowa hospitals had more services available which are often needed by long-term care patients.

- (7) Sixty percent of the nursing home administrators who answered the survey question on implementation of a national swing-bed program felt that such a program should be implemented, assuming certain eligibility restrictions, such as those mentioned in (10) and (11) below, would apply. Nursing home administrators in central Iowa were most receptive to a national swing-bed program, with 73.7% favoring a national program, compared to 56.9% in western Iowa/South Dakota, and 42.1% in Texas.
- (8) The benefit of swing-bed care mentioned most frequently by hospital staff members was the satisfaction of a need for long-term care in their respective communities. Comparison of benefits by project indicated that the staffs of Texas hospitals were less likely to report benefits as a result of providing swing-bed care than the staffs of hospitals in Iowa and South Dakota. The problems mentioned most frequently by hospital staff were inadequate reimbursement to hospitals for providing swing-bed care and inadequate orientation for physicians. Both of these problems were encountered in a larger proportion of the Texas hospitals.
- (9) The benefit of swing-bed care most often mentioned by nursing home administrators was the capacity of hospitals to provide long-term care when nursing home beds are unavailable. The problem most often mentioned by nursing home administrators was insufficient staffing in hospitals to provide both acute care and long-term care. There were no significant differences across projects in terms of either benefits or problems reported by nursing home administrators.
- (10) The majority of hospital and nursing home administrators felt a national program should be restricted to hospitals in rural areas without a skilled nursing facility in their service area.
- (11) Hospital administrators and nursing home administrators tended to disagree on both the levels of care which should be allowed under a national program and the number of long-term care services

which hospitals should be required to provide. The majority of hospital administrators felt that skilled and intermediate care should be included in a national program with both skilled and intermediate care, whereas only 30% of the nursing home administrators favored having intermediate care as part of a national swing-bed program. Of the five long-term care services mentioned in (4) above, the majority of hospital administrators felt that only one service, physical therapy, should be required for swing-bed hospitals, whereas most nursing home administrators felt that all five services should be required.

2. Utilization

- (12) By 1978, 51 rural hospitals were providing long-term care under the swing-bed experiments in Texas, Iowa, and South Dakota, accounting for about 30,800 days of care in that year. Hospitals admitting swing-bed patients in 1978 averaged approximately 605 long-term care days per facility. The average number of days per admitting hospital differed substantially by location, with South Dakota hospitals averaging approximately 1,180 long-term care days, western and central Iowa hospitals averaging about 550 days, and Texas hospitals providing slightly less than an average of 300 long-term care days in 1978. In 1978, one swing-bed hospital provided only 8 days of long-term care, while another provided 3,667 days.

- (13) In all, Medicare reimbursed for 37%, Medicaid for 3%, and private pay for 60% of the experimental long-term care days in 1978. Medicaid did not reimburse for swing-bed care in Texas or western Iowa in 1977. However, Medicaid did reimburse for skilled level care in Texas in 1978. The payer mix was substantially different between South Dakota and Texas, with Medicare paying for 23% of the long-term care days in South Dakota compared with 63% in Texas. Private pay accounted for 69% of the long-term care days in South Dakota, compared with 37% in Texas. Related to this, Texas hospitals provided only skilled nursing care, central Iowa and western Iowa hospitals provided approximately equal amounts of skilled and intermediate care and South Dakota hospitals provided all three levels of long-term care including personal care. For all hospitals combined, 50%, 41%, and 9% of the swing-bed care days provided were in the categories of skilled, intermediate, and personal care, respectively.

- (14) Mean length of stay for swing-bed patients in 1978 varied from 16 days at the skilled level to slightly over 172 days for personal care. Acute care occupancy and the number of days of long-term care provided in hospitals which admitted swing-bed patients in 1978 are negatively correlated. That is, hospitals with lower occupancy rates tended to provide more long-term care than those with higher occupancy rates.

- (15) For hospitals admitting swing-bed patients in 1978, hospital acute care occupancy rate was 43.3% in 1975, and 40.1% in 1978. Counting both acute care days and long-term care days provided under the swing-bed experiments, total occupancy rate for these hospitals in 1978 averaged 45.0%, 5.5 percentage points over the acute care occupancy for the same year. Acute care length of stay decreased from 6.71 days in 1975 to 5.64 days in 1978 for the hospitals which provided long-term care under the experiment in 1978. These changes in acute care occupancy and length of stay were paralleled by similar acute care utilization patterns in a group of comparison hospitals. Nonetheless, the decline in acute care length of stay was greater in admitting swing-bed hospitals than in the comparison hospitals suggesting that some acute care substitution may have taken place.
- (16) As is clear from Finding 12, the total amount of long-term care provided in the experimental swing-bed hospitals is relatively small compared with acute care. Similarly, swing-bed hospitals accounted for a very small proportion of total statewide long-term care days (provided predominantly by nursing homes) in 1977. In South Dakota, the state with the most swing-bed days, long-term care provided in swing-bed hospitals accounted for approximately 2% of the total long-term care days provided in 1977.
- (17) Long-term care utilization generally increased on a per capita basis between 1975 and 1977. Using South Dakota as an illustration, long-term care days per Medicare enrollee increased in project counties by 3%. A slight increase in the occupancy of existing nursing homes from 95% to 97%, the addition of 41 new nursing home beds, and the provision of long-term care by swing-bed hospitals accounted for this increase. The overall increase in long-term care utilization in the rural swing-bed counties and the fact that rural nursing home occupancy rates appear to have been unaffected by the availability of hospital swing-beds, indicate that virtually no substitution of swing-bed care for nursing home care took place as a result of the experiments.
- (18) If a swing-bed program were implemented nationally and all hospitals in rural communities (those not located in Standard Metropolitan Statistical Areas) were eligible to participate, it is estimated that the between 750,000 and 1,971,000 days of long-term care would be provided in hospital swing-beds, based on the 1978 utilization patterns observed in western Iowa/South Dakota and Texas swing-bed experiments. This would represent a 0.21% to 0.56% increase in total institutional long-term care utilization nationally.

2. Quality of Care

a. Case Mix Findings:

- (19) For long-term care patients in both swing-bed hospitals and comparison nursing homes the most frequently occurring categories of admitting diagnoses (primary and secondary) in both types of

facilities were neurological diseases, cardiovascular diseases, and musculoskeletal disorders. There were no overall patient diagnostic profile differences between the swing-bed hospitals and the comparison nursing homes in terms of the 16 diagnostic categories used to measure case mix from a medical care perspective.

- (20) The most frequently occurring general categories of patient long-term care problems (primary and secondary) in both types of facilities were nursing-oriented problems and psychosocial problems. There were significant overall profile differences between the hospitals and the nursing homes in terms of the 27 problems used to measure case mix from a long-term care perspective. Three significant proportional differences occurred consistently between the facilities for both primary problems and primary and secondary problems combined: secondary skin condition and pain were more frequent among hospital patients, while neurological immobility was more frequent among nursing home patients.
- (21) Swing-bed hospital patients were generally more independent than nursing home patients in terms of functional capabilities, as measured by activities of daily living (ADLs). The relative rankings (in order of functional independence in eight specific ADL categories) were the same for both facility groups, with the greatest number of patients independent in feeding and the fewest independent in bathing. There were, however, no overall differences between the facilities on the ADL Index, a measure of a patient's overall functional ability.
- (22) At the skilled level of care, there were no significant overall profile differences between the hospitals and nursing homes in terms of admitting diagnoses and the ADL Index. The overall long-term care problem profiles for skilled level patients were significantly different between the two facility types as were the three individual problems identified in finding (20) for all patients.
- (23) There were significant overall differences between hospital and nursing home patients in terms of additional patient characteristics such as demographic characteristics, sensory impairments, psychosocial status, medical condition, and level and type of care. Hospitals tended to have more short-term, rehabilitative, and male patients, more patients who demonstrated either physical improvement or psychological stability or improvement and patients with fewer speech and behavior problems. Nursing home patients had significantly more problems overall and significantly more sensory impairments and psychosocial problems. The numbers of nursing and medically-oriented problems were not significantly different between hospital and nursing home patients.

b. Quality of Care Findings:

Quality of care was measured primarily in terms of the adequacy of services provided to long-term care patients. It was measured at

four levels: for each service provided, for each individual patient problem (a patient could have several problems), for each patient, and, in the aggregate, for each facility. The service and problem level quality scores were most important since they allowed for a more detailed assesement of quality and were based on higher frequencies.

- (24) The quality of care provided in swing-bed hospitals was significantly lower than the quality of care provided in the comparison nursing homes, using the problem level quality scores developed as a part of this evaluation. The average nursing home problem quality score was 68.4% and the average hospital score was 64.0% out of a maximum possible score of 100%. This difference was of borderline significance at the patient level and not significant at the facility level.
- (25) The differences in problem-level quality scores between the swing-bed hospitals and the comparison nursing homes remained significant when skilled care patients were analyzed alone. Differences in patient level quality scores, however, disappeared when this control was introduced.
- (26) Problem level quality scores varied greatly by problem type. As a group the psychosocial problems had the lowest quality scores, and further, the hospital quality scores (45.1) were significantly lower than nursing home quality scores (61.5) in this problem area. The hospital problem quality scores were also significantly lower than the nursing home scores in treating the specific problems of primary skin condition; incontinence of urine; depression; and loneliness, isolation and lack of socialization. When skilled level patients were analyzed separately, the differences in psychosocial problem scores remained significant. In terms of specific problems, quality scores were significantly lower for skilled level hospital patients in the areas of depression and loneliness, isolation, and lack of socialization.
- (27) Analysis of services by categories indicated that the nursing homes provided significantly better social-recreational, therapeutic-mental health, physical and occupational therapies, professional nursing, and physician services than the hospitals. The hospitals, however, provided significantly better lab and non-professional nursing services. When skilled level patients were considered separately, these differences between facility types remained except swing-bed hospitals provided significantly better physical and occupational therapies to skilled level patients than the nursing homes. The four service categories in which the hospitals provided consistently poorer quality care were further examined to determine the patient problem areas in which the services were deficient. Social-recreational and therapeutic-mental health service scores were significantly lower for psychosocial problems, professional nursing services were lower for nursing-oriented and for psychosocial problems, and physician services were lower for both nursing and medically-oriented problems.

- (28) In the swing-bed hospitals, skilled level patients received consistently higher quality care than intermediate level patients when measured at the patient, problem, and service levels. Specifically, skilled level patients with nursing-oriented problems received significantly higher quality using problem level quality scores. For all types of service categories, skilled level patients had higher scores than intermediate patients. These scores were significantly higher for physical and occupational therapies, laboratory, professional nursing, and pharmaceutical services.
- (29) Physicians visited long-term care patients in swing-bed hospitals significantly more frequently than patients in the comparison nursing homes. For the hospitals, 86% of the long-term care patients were visited weekly or more often, compared with 17% of the nursing home patients.
- (30) Written discharge plans were present significantly more often for comparison nursing home patients than swing-bed hospital patients. For the comparison nursing homes, 63% of the medical charts contained written discharge plans, compared with 28% for the swing-bed hospitals. Further, 67% of the hospital patients were expected to be discharged within three months, while only 18% of the nursing home patients were expected to be discharged in this time period.
- (31) Six long-term care services were available more frequently in a group of 33 Medicare-certified skilled nursing facilities (in the three experimental states) than in the swing-bed hospitals. The six services studied constitute key long-term care services required under the Medicare/Medicaid conditions of participation which were waived for the experimental hospitals. The percentage of all swing-bed hospitals providing each service (in order of increasing frequency) was: occupational therapy (5%), patient activities (16%), speech therapy (17%), social services (36%), dental services (52%), and physical therapy (53%). The greatest discrepancies between the nursing homes and hospitals were in the availability of patient activities and social services.

c. Correlates of Quality:

Using the patient-level quality scores discussed above, several analyses were conducted in order to determine the extent to which several factors were related to the quality of care provided in swing-bed hospitals and comparison nursing homes.

- (32) Case mix was not as significant a correlate of quality provided in nursing homes as it was for hospitals. In the swing-bed hospitals, case mix explained 43.2% of the variation in the quality of care, whereas it only explained 23.5% of the variation in the quality of care in the nursing homes.
- (33) There were significant differences between the hospitals and the comparison nursing homes in terms of the relationships

of two attributes to quality of care measured at the patient level. The number of psychosocial problems was a negative indicator of quality in the hospitals but was not related to quality in the nursing homes. The problem of dependent edema, a medically-oriented problem, was a positive indicator of quality in the hospitals but not in the nursing homes.

- (34) Community, facility, and case mix characteristics of the swing-bed hospitals explained 47.4% of the variation in patient-level quality. The addition of characteristics related to the swing-bed experiments significantly increased the explanation of the variation in patient level quality by 9.9%.
- (35) Overall, 57.3% of the variation in patient-level quality for swing-bed hospitals was explained by case mix factors (number of psychosocial problems, patient age, and dependent edema problem), facility size, presence of long-term care services, and nursing time. Case mix attributes considered more prevalent among typical long-term care patients (old age and number of psychosocial problems) were negatively associated with patient quality. Dependent edema, a medically-oriented problem, was positively associated with quality. Larger hospitals tended to provide higher quality of care, while nursing time per swing-bed patient day and the presence of long-term care services (i.e., those which are required of skilled nursing facilities, but which were waived for the experimental hospitals) were positive correlates of quality.

4. Finance

- (36) In 1978, the incremental cost of routine care per long-term care patient day averaged \$8.91. As mentioned, this estimate is based on the incremental cost formula used as part of the experimental program. Using the calculation formula developed for the evaluation, which included more cost centers, the average was \$15.62 in 1978.
- (37) Using the standard Ratio of Charges to Charges Applied to Cost (RCCAC) method, the ancillary cost for swing-bed patients was \$9.97 per Medicare patient day in 1977 (the most recent year for which data were available).
- (38) The full cost of routine care for swing-bed patients was \$75 per long-term care patient day in 1978, substantially higher than the incremental cost per day.
- (39) The routine cost per long-term care patient day for certified nursing homes in Texas, Iowa and South Dakota averaged \$25.70 in 1977. This amount was lower than the full cost of routine care per long-term care day in swing-bed hospitals during the same time period, but higher than the incremental cost per long-term care patient day under the swing-bed program.

- (40) Except for a few hospitals, the experimental swing-bed program did not appear to strengthen the financial position of the participating hospitals. Long-term care revenues from routine care averaged 2.82% of total patient care revenue in 1978. In general, long-term care revenue exceeded incremental cost; but the program appears to have had little discernible effect on the financial position of hospitals since the amount of total utilization accounted for by long-term care patients was small.
- (41) In 1977, the reimbursement system for swing-bed care resulted in the Medicare program experiencing a reduction in routine acute care reimbursement which was greater than increased expenditures for swing-bed care in South Dakota, Texas, and central Iowa. When the reduction in routine acute care reimbursement was subtracted from expenditures for swing-bed care, the resulting amount (the net payment) was less than incremental cost. In South Dakota, where Medicaid reimbursed for both acute and swing-bed care in 1977, the reduction in routine care cost was less than the increase in expenditures for swing-bed care but the net payment was also less than incremental cost for Medicaid patients. In this situation, it appears that private pay patients receiving long-term care in swing-bed hospitals were subsidizing patients paid for by Medicare and Medicaid; that is, private pay patients paid for care at a rate higher than incremental cost.
- (42) Because the quality of long-term care is slightly higher in nursing homes than in experimental swing-bed hospitals and because the incremental cost of long-term care is lower in swing-bed hospitals than in nursing homes, a cost-effectiveness analysis, based on the ratio of quality to cost, was conducted for the two facility types. This assessment indicates that the provision of long-term care in swing-bed hospitals is more cost-effective than providing institutional long-term care in nursing homes, based on the incremental routine cost (rather than the full cost) of long-term care provided in swing-bed hospitals. When full cost is used, the same type of analysis indicates that nursing homes are more cost-effective than swing-bed hospitals.
- (43) Projections of the cost of a nationwide swing-bed program, based upon the estimates of nationwide utilization presented earlier, ranged from \$14.2 million to \$37.0 million. This is based upon an estimated range for routine long-term care and ancillary long-term care. These projections do not take into consideration the possibility of a reduction in hospital expenditures should payments for swing-bed care replace current expenses for administratively necessary days. To the extent that a national swing-bed program would involve some savings of this sort, expenditures for hospital care may be less than what is projected here.

CHAPTER III

POLICY CONCLUSIONS

A. INTRODUCTION

The evaluation described in this report was designed for two general purposes. First, it was intended to provide information relevant to a policy decision on whether to extend the swing-bed approach beyond the experimental stage to national implementation. Second, given the possibility that attainment of the first objective would result in a recommendation to proceed with a national program, the study was designed to anticipate problems and provide guidelines pertinent to more widespread implementation of the swing-bed approach. With respect to the first objective, the results of this study suggest that a swing-bed program should be implemented in rural communities nationally. General conclusions, potential problems, and specific recommendations associated with national implementation are contained in the implications presented throughout this chapter.

The general recommendation to establish a national swing-bed program is premised on (1) an unmet demand for long-term care which appears to exist in many rural communities, (2) the assumption that the satisfaction of this demand is socially desirable and will enhance the public welfare, (3) the conclusion that many rural hospitals can and will provide such care in an adequate manner if proper quality assurance steps are taken, and (4) the fact that the cost of swing-bed care will not exceed the cost of comparable care provided in other settings. It should be emphasized that this study was not designed to analyze the cost-effectiveness of every possible alternative to providing long-term care in rural communities. Nonetheless, the most realistic and available alternative for rural communities, nursing home care, was examined taking into consideration the cost and quality of nursing home care. The study conclusions are thus premised on an assessment of the demand for and cost of the two most pragmatic alternatives for long-term care in rural communities, i.e., swing-bed care and nursing home care, as well as the quality of care associated with each alternative.

The general suggestions for implementation of a swing-bed program may be categorized into four areas: provider eligibility, reimbursement, quality assurance, and orientation/information dissemination. The following remarks summarize the major conclusions in these areas, which are subsequently discussed in greater detail in Section B.

With respect to provider eligibility, the recommendations which follow state that rural hospitals throughout the country should be allowed to provide swing-bed care. That is, they should be eligible to receive Medicare and Medicaid reimbursement for long-term care provided in swing beds in accord with certain reimbursement and quality assurance

guidelines. Individual states should then be permitted to impose further restrictions through the certificate of need process.

Medicare and Medicaid reimbursement should be structured to ensure that the incremental cost of long-term care provided in swing beds will be covered. The establishment of a per diem reimbursement rate on the basis of nursing home cost experience along with a revenue offset method for reimbursement would accomplish this and, at the same time, provide the basis for a reasonably cost-effective approach for all payers, including private payers.

The quality component of this evaluation has indicated that acute care hospitals are capable of providing adequate long-term care, but are less likely to provide certain non-medical services in as adequate a manner as many nursing homes. Hospital-based long-term care provided in swing beds should thus be subject to standard PSRO review procedures. Furthermore, hospitals should be required to satisfy some, but not all, of the Medicare/Medicaid conditions of participation which currently regulate skilled nursing facilities.

Orientation/information dissemination is critical to the success of a national swing-bed program, especially in terms of patient care practices and overall program management. Clearly written guidelines for physicians and nurses on the provision of long-term care and the differences between long-term and acute care should be available and disseminated to each eligible hospital. Similarly, administrative guidelines detailing reimbursement policy, forms completion, and anticipated hospital-level problems should be disseminated to hospital administrators. Planning and fiscal agencies (including Medicare intermediaries and state Medicaid programs) should also be provided information on various system-wide regulatory and financing considerations.

Each implication discussed below falls either into the category of broad conclusions and potential problems, or into one of the previously mentioned areas of provider eligibility, reimbursement, quality assurance, and orientation/information dissemination. Some implications pertain to more than one such category. For clarity of exposition, however, the implications are presented according to generic health care or regulatory topic areas which lend themselves to policy considerations.

B. PROGRAMMATIC IMPLICATIONS

1. General Recommendations on National Implementation

The results of this study suggest that a swing-bed program should be implemented nationally. Five general findings constitute the rationale behind this recommendation:

- (a) An unmet demand for institutional long-term care exists in many

rural communities. The results of this study indicate that the long-term care utilization experience of the swing-bed hospitals was not due to a diversion of long-term care patients from nursing homes, but instead represents a demand which previously had not been met. It appears, therefore, that many rural communities may be in need of additional long-term care beds. Moreover, the availability of swing beds in rural areas reduces travel time and related inconveniences for the families and friends of long-term care patients, thereby increasing the likelihood of a stronger social support system for the long-term care patient.

- (b) Assuming it is desirable to service the institutional long-term care needs of rural communities in a more effective manner than is presently being done, the swing-bed approach appears to be the most cost-effective (based on incremental cost) means to do so. While the total cost of health care in this country would increase slightly with the inception of this program (as indicated in Implication 4 below), the unit cost, i.e., cost per long-term care patient day, under a swing-bed approach would be less than the cost associated with providing similar care in nursing homes.
- (c) The quality of long-term care provided in swing-bed hospitals is adequate. While the experimental hospitals as a group did not provide care as well as comparison nursing homes, the discrepancy was not substantial and, in addition, is likely to disappear over time with the proper quality assurance steps and as the staffs of swing-bed hospitals become familiar with the special problems of the long-term care patient.
- (d) Although the swing-bed concept has encountered some resistance, there was, in general, an acceptance among hospital staff in the experimental setting. At the administrative and patient care levels there appear to be no insurmountable obstacles which would substantially impede the provision of swing-bed care in rural hospitals. The problems encountered can very likely be dealt with over the course of time using appropriate orientation and information dissemination procedures such as those suggested in subsequent implications.
- (e) The swing-bed approach represents a method of rural hospital diversification. An acute care hospital in a rural area is often highly important to the economy of the community. Further, while the value of retaining an acute care hospital to service the emergency and acute care needs of a rural community may be difficult to measure, it is generally regarded as substantial, especially by community residents. The swing-bed approach, therefore, should be viewed as beneficial in more ways than those directly related to the long-term care needs of rural areas, and is in keeping with the current movement to encourage rural hospitals to become involved in a more diversified program of health care (and even

non-health care) service delivery.

2. Provider Eligibility Under a National Program

Initially, hospital participation in a national swing-bed program should be restricted to (1) hospitals located in rural areas (i.e., outside Standard Metropolitan Statistical Areas, as defined by the U.S. Census Bureau), and (2) hospitals which have satisfied state level certificate of need requirements to provide long-term care. Since the experimental programs took place only in rural communities, it was beyond the scope of this evaluation to determine either the existence of unmet demand in metropolitan areas or the ramifications of implementing a swing-bed program in such communities. A large number of factors peculiar to the urban environment (and not examined in this evaluation) have the potential to influence cost, utilization, and the quality of long-term care which would be provided in swing-bed hospitals. For this reason, therefore, it is recommended that eligibility be initially restricted to rural hospitals with possible future experimentation and research designed to assess the appropriateness of swing-bed care in metropolitan areas.

In order to provide maximum flexibility, no overall limitations on hospital participation (except for the restriction to rural locations) such as the experimental limits on hospital bed size, acute care occupancy, or long-term care utilization, are recommended. Instead, the decision on whether swing beds are needed at the local level should be the responsibility of state level certificate of need agencies. Such agencies are often in a better position to ascertain the need for additional long-term care beds in rural communities and should be left free to impose those limitations on hospital eligibility which are most appropriate at the state level.

3. Utilization Projections

It is not possible to precisely estimate the utilization which will occur if a swing-bed program is implemented nationally. Several factors render it difficult to forecast utilization: (1) payers participated to differing degrees across the various experiments; (2) the distribution of patients within different levels of long-term care varied from experiment to experiment; (3) reimbursement procedures differed; (4) administrative practices differed at both the hospital and state levels; and (5) it is not possible to stipulate the precise eligibility and regulatory conditions which might be associated with a national program. Nevertheless, it is possible to predict utilization within very broad ranges:

- (a) If the program is implemented nationally using the eligibility criteria of location in a rural area and satisfaction of state certificate of need requirements, swing-bed utilization in rural hospitals is likely to total between 750,000 and 1,971,000 long-term care days per year within one to two years following implementation of the program.

- (b) This would represent a 0.21% to 0.56% increase in institutional long-term care utilization nationally.

4. Cost Projections

As indicated in Chapter II, routine care refers to basic room and board, nursing, and related services, while ancillary care refers to services such as diagnostic, laboratory, and x-ray services which are normally provided on a discretionary basis in accord with individual patient needs.

- (a) Routine Cost Projections. The incremental cost to the swing-bed hospital of providing routine long-term care averaged \$8.91 per patient day in 1978. Employing the eligibility criteria given in Implication 2 and multiplying this incremental cost by the projected number of days given in Implication 3 above yields a routine cost range of between \$6.7 million and \$17.6 million per year for the provision of swing-bed care.
- (b) Ancillary Cost Projections. Using the standard Ratio of Charges to Charges Applied to Cost (RCCAC) method, the ancillary cost for Medicare swing-bed patients was \$9.97 per long-term care patient day in 1977 (the most recent year for which data were available). Multiplication by the utilization figures given earlier yields an estimated 1977 ancillary cost of between \$7.5 million and \$19.5 million if the program had been operated on a national basis.
- (c) Total Cost Projections. The total cost of implementing a swing-bed program from the perspective of cost to the hospital (and ultimately to payers and consumers) is the sum of the appropriate figures given in (a) and (b) above; and thus, the total cost if the program had been implemented in 1978 would have been between \$14.2 million and \$37.0 million.¹ The impact of such an addition on total national hospital care expenditures would be minimal, since the additional costs would represent an increase of between .02% and .05%. From the point of view of unit cost, however, the swing-bed approach represents a cost containment mechanism when the incremental cost of routine care for swing-bed hospitals, \$8.91 per day, is compared with the routine cost of \$25.70 per day associated with skilled nursing home care.²

¹These figures slightly underestimate total costs for 1978 since ancillary cost projections were based on data available only for 1977. In order to project costs for 1981 or future years, it is appropriate to apply an inflation factor to the figures presented here.

²This evaluation has provided some evidence to suggest that acute care length of stay may be decreased for patients who are transferred from acute care to long-term care in swing-bed hospitals. It is possible, therefore, that acute care costs might be reduced in locations where patients are "held" in acute care status due to the lack of long-term care beds in the area.

Further, this expected one time rate of increase in cost, between .02% and .05%, is substantially less than the annual inflation rate in hospital costs.

- (d) Administrative Costs. This evaluation has dealt largely with cost to the hospital, which is ultimately passed on to reimbursers and consumers in a manner determined by reimbursement procedures. The administrative costs (both to hospitals and payers) of reimbursing for swing-bed care are regarded as negligible relative to the actual cost of patient care.

5. Reimbursement Guidelines

Since Medicare, Medicaid, and private payers are the primary sources of institutional long-term care revenues, the recommended reimbursement guidelines presented here pertain to these three payer groups. The reimbursement procedures suggested are intended to cover the incremental cost of long-term care rather than the full cost of such care. The recommended procedure is such that the total portion of hospital cost reimbursed by any given payer may differ from the actual incremental cost of patient care, depending on the percentage of long-term care and acute care utilization attributable to patients covered by that payer. The recommended procedure, moreover, maintains a crucial element of the experimental system which is that cost finding will not be used to determine the incremental cost of swing-bed care; instead, long-term care revenues will be treated as an approximation to cost and offset against routine care cost. It is more likely that hospitals will use the swing-bed approach when it is handled in this manner because of the administrative ease with which this can be incorporated into the hospital's current record keeping and cost reporting practices.

(a) Medicare

- (1) Routine Care. Medicare would reimburse only for skilled level care by prospectively establishing a per diem rate equal to the fiftieth percentile (median) of the Medicaid skilled level average cost per day for nursing homes in each state. If the state Medicaid program uses standard inflation adjustments or other factors based on region or facility characteristics, a similar procedure would be used in setting the Medicare swing-bed per diem. The Medicare acute care settlement would require the hospital to (a) calculate routine costs without attempting to separate costs incurred due to the provision of long-term care and (b) reduce the calculated routine costs by the amount of long-term care revenues (net of bad debts, etc.) from all payers (Medicare, Medicaid, private pay, etc.).

This routine care reimbursement procedure represents a departure from standard Medicare practice in that it is not based

on full cost of services, but is intended only to ensure that the incremental cost of care is covered. Implementation of such a procedure may result in requests for similar treatment of other hospital services and may therefore bring about a reconsideration of Medicare reimbursement policy in other areas.

(2) Ancillary Care. Medicare reimbursement for ancillary services received by swing-bed patients would be handled according to standard Medicare procedure. That is, hospitals would be required to determine the cost of ancillary services to swing-bed patients using the Medicare Ratio of Charges to Charges Applied to Cost (RCCAC) method. This would require no change in current Medicare reimbursement policy for ancillary services provided in acute care hospitals.

(b) Medicaid

(1) Routine Care. Where possible, Medicaid programs should use the same rate as Medicare (calculated using the procedure described above), which is, in fact, based on Medicaid cost experience, when reimbursing for skilled nursing care provided in hospital swing beds. The Medicaid rate(s) for intermediate care should be set at the fiftieth percentile of statewide Medicaid cost per day for intermediate care delivered in free-standing facilities. Where appropriate, for states which employ more than one level of skilled and/or intermediate care, the Medicaid rates for swing-bed hospitals should be established according to these categories. Further, in those instances where states use adjustments for inflation, facility, or regional differences, this should be built into the Medicaid routine care per diem for long-term care provided in swing-bed hospitals. The offset method for routine care reimbursement described under (a.1) above should be used for the acute care settlement.

(2) Ancillary Care. Three alternatives are suggested, with each state Medicaid program electing the alternative which best suits its current policy and practices:

- a. Where possible, the Medicare RCCAC method should be used.
- b. Where state nursing home practices currently use such an approach, state per diem payments for swing-bed care should be inclusive of ancillary care reimbursement.
- c. When in accordance with current state practices, a fee-for-service system should be used.

(c) Private Payers

Although it is beyond the purview of Medicare and Medicaid regulations, it is recommended that the charge structure for private pay patients who receive long-term care services in swing-bed hospitals be the same as that for Medicaid patients. Some states, such as Minnesota, currently require this by state law.

6. Levels of Care

The swing-bed evaluation has demonstrated that the quality of care provided to skilled nursing patients is slightly lower in swing-bed hospitals than in skilled nursing facilities.³ The evaluation also showed that the quality of care provided to intermediate care patients in swing-bed hospitals is slightly below that provided to skilled level patients. Yet, since these differences are not substantial and appear likely to decrease over time, it is recommended that swing-bed hospitals be allowed to provide both skilled and intermediate care subject to the regulatory criteria given in Implication 7.

Although custodial or residential care is more likely to be provided by nursing homes than swing-bed hospitals, it is recommended that hospitals not be restricted from providing such care. The rationale behind this recommendation is that many states currently allow hospitals to classify private pay patients as acute care patients, charging them whatever they wish. Thus, if the hospital preferred to provide custodial care and classified the patient as an acute care patient, charging the individual patient at a lower rate, it could not be restricted from doing so. Nonetheless, the evidence produced by this evaluation regarding the quality of care available for residential care patients in swing-bed hospitals is inconclusive. There is some concern that swing-bed hospitals may not be able to provide the social and emotional support services needed by such patients as well as nursing homes.

7. Quality Assurance for Long-Term Care Patients in Swing-Bed Hospitals

The following findings and general observations are pertinent to the issue of quality assurance: (1) many hospital personnel were not familiar with or experienced in treating the needs of long-term care patients; (2) swing-bed hospitals tended to be inadequate, relative to nursing homes, in treating the patient problems of depression, loneliness, isolation, and lack of socialization; (3) nursing homes appeared to be more capable of providing social-recreational and therapeutic-mental health services; (4) swing-bed hospitals provided lower quality of care to intermediate level patients (who often have

³However, the certified skilled nursing facilities used in the quality study may well have been above average with respect to the care provided in each facility.

fewer medical and more psychosocial problems) than skilled level patients; and (5) written discharge plans were not present for the majority of long-term care patients in swing-bed hospitals. As a result, it is recommended that a national swing-bed program implement the following quality assurance measures.

- (a) Enforce the section of the Medicare/Medicaid conditions of participation for skilled nursing facilities on staff development (CFR 405.1121 (h)) which states, "An ongoing program is planned and conducted for the development and improvement of skills of the facility's personnel, including training related to problems and needs of the aged, ill, and disabled."⁴ This requirement would assist in orienting swing-bed hospital personnel to the special needs of long-term care patients, an area where hospitals appear to be deficient.
- (b) Enforce the Medicare/Medicaid conditions of participation for social services (CFR 405.1130 (a)-(c)). This requirement is designed to meet the special social and emotional needs of long-term care patients. It requires that these needs be identified and that appropriate services be provided by hospital staff, or by referral to providers outside the hospital.
- (c) Enforce the major provisions of the Medicare/Medicaid conditions of participation for patient activities (CFR 405.1131 (a)-(b)). In the provision of patient activity programs, the swing-bed hospitals need not be required to provide separate dining and patient activity rooms. This requirement is intended to promote the physical, social, and mental well-being of the patients without burdening hospitals with additional capital costs which would not be justified on the basis of small long-term care case loads. To the extent that swing-bed hospitals have excess space capacity, they should be encouraged to provide additional space for long-term care patient activities in a flexible manner.
- (d) Enforce the Medicare/Medicaid discharge planning standard (CFR 405.1137 (h)). This requirement will help ensure continuity of care for long-term care patients discharged from swing-bed hospitals. Such patients, unlike typical acute care patients, usually need institutional care after discharge from the facility.
- (e) Include swing-bed patients under PSRO and Medicaid long-term care review programs which are currently being implemented in many areas. Participation in such programs would serve to

⁴References are to the Code of Federal Regulations.

ensure against inappropriate patient placement and also serve a continuing education role of potential value to hospital staff members involved in the provision of long-term care.

8. Information Dissemination

The innovative nature of the swing-bed concept increases the importance of information dissemination in explaining the various aspects of the program to eligible hospitals. The following recommendations pertain to this function.

- (a) Under a national swing-bed program, information dissemination on all topics (with the exception of reimbursement which is discussed in (c) below) should consist of written materials sent to all eligible hospitals. These materials, which might be based on those prepared for the orientation programs carried out in the experiments, should be revised to reflect the experience of hospital administrators, directors of nursing, chiefs of staff, and staff physicians in participating hospitals. In addition to the specific items discussed under (b) and (c) below, the following general topics should be covered:
 - (1) Potential benefits to hospitals, patients, and communities;
 - (2) Explanation of applicable regulations and eligibility requirements, especially certificate of need requirements and any conditions of participation not waived for swing-bed hospitals.
 - (3) A general description of the difference between acute and long-term care patients, emphasizing the special needs of long-term care patients and the changed roles which hospital medical and nursing staff must play in providing long-term care.
- (b) In the area of quality of care, the written materials should consist of guidelines and educational materials which concentrate on the provision of long-term care to patients who need more restorative and social services than the typical acute care patient. This information should focus on the appropriate provision of restorative, general medical, nursing, and physician services required by SNF conditions of participation not waived for the swing-bed program. In this regard, it may be appropriate to consider the criteria sets used in the quality component of this evaluation as the basis for such a program. The criteria sets were constructed for purposes of assessing the quality of care provided to swing-bed patients and can be utilized to provide recommendations for specific areas where hospitals are deficient.
- (c) In the area of reimbursement, use of an orientation approach, rather than reliance on written materials, is recommended for two reasons. First, while reimbursement-related problems were relatively common, they were due in large measure to a lack of understanding of the

incremental cost concept. Second, there already exists a formal mechanism, the network of Medicare fiscal intermediaries, which can carry out this orientation function with a relatively small additional expenditure of time and money. Topics covered would include: (1) rationale for incremental cost reimbursement; (2) actual reimbursement procedures for routine and ancillary long-term care; (3) relationship of per diem incremental reimbursement to incremental cost; (4) effect of swing-bed care reimbursement on acute care allowable cost and reimbursement; (5) effect of swing-bed care on total hospital reimbursement; (6) required changes in claims procedure; and (7) required changes in cost reporting. The findings presented in Chapter II of this report can provide the basis for the information used to cover points (3) through (5) above.

9. Hospital Incentives

The two primary incentives associated with the provision of long-term care in hospitals in rural communities are:

- (a) Community Service. The most commonly cited incentive for the provision of swing-bed care is likely to be the benefit which accrues to the community in which the hospital is located. This will result from both increased availability of adequate institutional long-term care and the continued presence of an acute care facility which is enhanced by the provision of long-term care.
- (b) Diversification. The swing-bed approach will increasingly be viewed by hospital staff as an opportunity to increase hospital efficiency and to move toward diversification of rural hospital service programs with the ultimate goal of increasing the organizational and fiscal viability, as well as community value, of rural hospitals.

10. Expected Problems in Implementation

- (a) Reimbursement. The accounting and financial capabilities of rural hospitals are not as sophisticated as those of larger metropolitan hospitals. It is likely that hospital administrative staff will have difficulty with the reimbursement policies and processes associated with providing a new type of care. The offset method of reimbursement recommended in Implication 5 is novel in the hospital setting and it is reasonable to anticipate that the concept of basing reimbursement on incremental cost initially will appear inequitable from the hospital perspective. For these reasons, it is important that reimbursement policy be clearly stated, straightforward, and well understood from the outset.
- (b) Patient Care and Quality Assurance. Hospital medical, nursing, and administrative staff will have certain difficulties adjusting to the different health care needs and service requirements of long-term care patients. In particular, the greater emphasis on rehabilitative and maintenance services associated with long-term

care and the psychosocial nature of many long-term care problems will require adjustments by the hospital staff which should be expected to take place over the course of time. The quality assurance recommendations in Implication 7 and written patient care guidelines and educational programs in Implication 8 should be seriously considered and efficiently implemented.

- (c) Resistance to Change. Although a national swing-bed program will ultimately be of benefit to rural hospitals and patients alike, it is reasonable to expect initial resistance to the program in many rural communities. This resistance will arise from a natural aversion to "federal intervention", the attitude on the part of some that an acute care hospital "should not become a nursing home", and a general concern about changing the role of acute care hospitals in certain communities. A national swing-bed program should definitely be voluntary and supportive of an expanded referral network among swing-bed hospitals and nursing homes.
- (d) State Level Considerations. Issues of licensure and rate regulation must be dealt with at the state level. State licensure policy may require that both hospitals and hospital administrators receive institutional and professional licenses, respectively, in order to provide long-term care in rural hospitals. Given that the intent of licensure is to ensure that a minimal level of care is provided, it is recommended that professional and institutional licensure requirements at the state level be waived for hospital administrators and swing-bed hospitals--in view of the quality assurance recommendations provided here and the fact that hospital staff and administrators are normally experienced in the provision of medical care. In addition, state level hospital rate commissions and, where appropriate, nursing home rate setting agencies must be appraised of the reimbursement and financial aspects of a national swing-bed program at the state level.
- (e) Transition Between the Experiments and a National Program. Should Congress decide to implement a swing-bed program, it is possible that the experimental projects will end before federal enabling legislation takes effect. During the course of the experiments, several extensions were granted as the projects neared scheduled completion dates. The uncertainty as to whether the projects would continue created problems at the community, hospital, and patient levels. To avoid these difficulties, it is recommended that legislation allow the current experimental hospitals to continue to provide swing-bed care prior to the official implementation date of a national program.
- (f) Rural Hospitals Which Currently Provide Long-Term Care. While the substantial majority of rural hospitals are not involved in the provision of long-term care, some hospitals do have certified

distinct-part facilities, own or manage nearby nursing homes, or are involved in long-term care in some manner. It is recommended that the swing-bed program apply only to the acute care beds in such institutions. Specifically, hospitals should continue to be reimbursed in accord with standard long-term care reimbursement policy for care provided in already-existing long-term care beds. If the swing-bed reimbursement procedure were applied to care provided in existing long-term care beds, it would imply that such beds could also be used to provide acute care. This would lead to the need to count such beds as both acute and long-term care beds, raise issues of certification and accreditation, and in general, lead to regulatory, reimbursement, administrative, and patient care problems which need not occur in the context of this type of program. Hence, it is recommended that a swing-bed program pertain to existing acute care beds in rural hospitals, not to existing long-term care beds.

11. Swing-Bed Care in the Context of Current Trends in Health Care

- (a) Finance. Concerns about health care cost containment will continue to give rise to programs based on efficient utilization of existing health care facilities. The swing-bed program and the experimental reimbursement scheme, a variant of which is recommended in Implication 5, are consonant with increased concerns about flexible reimbursement and cost-effectiveness in health care.
- (b) Long-Term Care. During the past several years that portion of our population which requires institutional long-term care has received increased attention. Such attention is appropriate and will continue to grow over the next decade. The swing-bed program represents one of several responses to the need to provide adequate health care to a continually increasing proportion of individuals requiring long-term care in this country.
- (c) Diversification. As mentioned earlier, the trend toward an expanded service mix for rural hospitals has been established during recent years. The swing-bed program represents one of several mechanisms for increasing the viability of the rural hospital and its benefit to the rural community.
- (d) Quality Assurance. Health care quality assurance has taken on increased importance during the past decade. The quality component of the evaluation discussed in this report, the recommendations regarding quality assurance, and the increased activities in long-term care quality assurance all are in keeping with this trend. If the swing-bed program is implemented nationally, the quality assurance program which accompanies it must clearly be in keeping with the general trends in quality assurance issues and policies.
- (e) Rural Health. It is generally recognized that the problem of

access to adequate health care persists in rural communities. Valid cost containment efforts have given rise to suggestions that hospitals in many rural communities ought to be closed. Yet, it is also recognized that a program designed to close a large portion of rural hospitals is likely to intensify the access problem in rural communities. The swing-bed program not only assists in increasing access to long-term care, but it also represents a means of efficiently assisting in the preservation of existing acute care facilities for rural residents.

- (f) Experimentation and Evaluation. Certain governmental and non-governmental organizations have emphasized and supported the need for experimentation with different approaches to health care prior to implementing new health care policy on a broad scale. The swing-bed experimental and evaluation programs are part of this growing trend. Although the experimental program has not provided answers to all possible questions regarding national implementation, it has provided a substantial amount of objective information upon which to base policy decisions.

C. RESEARCH IMPLICATIONS

1. Extension of Swing-Bed Care

Consideration of whether the swing-bed program should be extended to hospitals in metropolitan areas entails a number of factors which the rural swing-bed experimental and evaluation program was not intended to address. For example, problems of access to both acute and long-term care, the range of health care facilities available to consumers, referral networks among different types of health care providers (including physicians, nursing homes, and hospitals), the presence of multiple long-term care facilities, lifestyle, community attitudes, and community economics are substantially different in metropolitan and rural areas. Yet, as the percentage of individuals in need of long-term care, especially the elderly, increases, there is reason to ask whether the supply of nursing home beds in metropolitan areas will continue to meet institutional long-term care needs. Given that such needs might best be served by hospitals offering swing-bed care, a demonstration project which would allow for the provision of swing-bed care in several metropolitan areas might be of value in determining whether and how a swing-bed program should be extended.

2. Cost and Quality

Issues of health care cost, financing, and reimbursement will continue to receive increased attention. However, decisions as to how certain types of health care programs should be financed should be based not only on program costs, but on expected benefits. Many health care decisions in the past have been made under the assumption that the quality of care to be provided under a particular program would be adequate. Basically,

such decisions rest on the assumption that the "effectiveness" portion of a cost-effective program is a foregone conclusion. Research and policy deliberations should continue to stimulate and foster the appropriate measurement of the quality of care, especially in terms of the provision of adequate services for specific patient problems or typologies. The influence of the provision of services on changes in health status should also continue to be studied. Information collected through studies aimed directly at measuring quality would facilitate decision making associated with implementation, change, or discontinuation of various types of health care programs.

3. Experimentation and Evaluation

The utility of experimentation with a particular health care program of potential value is currently being demonstrated through several efforts. This approach to decision making is not without its problems, however. It requires planning and patience, and occasionally runs counter to the time frame of policy deliberations designed to implement a program either without experimentation or before information generated through a demonstration project is available. Issues of health care cost and quality, trade-offs among them, concerns regarding the most cost-effective alternatives for meeting specific health care needs, national health insurance, etc., will continue to increase in importance and should be addressed from the perspective of an empirical information base as well as conceptual reasoning. An empirical approach to the evaluation of potential health care programs is consistent with the need to support adequate information collection and dissemination on the structure and performance of our nation's health care system.

4. Flexible Reimbursement and Regulation

The evaluation documented by this study has recommended a method of reimbursement which follows from estimating the incremental cost of long-term care, establishing a payment rate which covers and slightly exceeds incremental cost, and offsetting long-term care revenues against acute care costs. This reimbursement procedure has been suggested since the most accurate reimbursement mechanism, which would be based on a detailed determination of the true cost of swing-bed care, would substantially increase the overall cost of the program. In the process of making this recommendation, a trade-off between excess cost and overall equity to payers was carefully weighed. The recommended reimbursement scheme requires a greater degree of flexibility in Medicare and Medicaid reimbursement policy than more detailed accounting schemes might require. Yet, from the point of view of overall cost-effectiveness, the offset method of reimbursement seems appropriate for a swing-bed program. Health care reimbursement and regulatory policy in this country is large-scale and somewhat cumbersome. Research on increasing regulatory and reimbursement flexibility should therefore be conducted with a view toward an evolving and continually changing regulatory system which will foster rather than impede cost-effective approaches to health care.

APPENDIX A

Earlier reports in the swing-bed evaluation series have dealt with research design issues, describing the overall research approach and methodology of the evaluation, activities, and preliminary findings. Study publications are listed below.

Working Paper 1: Research Design for Reducing Acute Care Costs Evaluation, June 1977.

Working Papers 2-5: Evaluation of Experiments to Provide Long-Term Care in Rural Hospitals: Research Design, September 1977.

Evaluation of Experiments to Provide Long-Term Care in Rural Hospitals: History, December 1977.

Working Paper 6: Evaluation of an Experiment to Provide Long-Term Care in Rural Hospitals: A Status Report of the Organization Component of the Evaluation, March 1978.

Evaluation of an Experiment to Provide Long-Term Care in Rural Hospitals: First Year Report, March 1978.

Working Paper 7: Swing-Bed Experiments to Provide Long-Term Care in Rural Hospitals in Iowa, South Dakota, and Texas: A Status Report on the Financial and Utilization Components of the Evaluation, September 1978.

Swing-Bed Experiments to Provide Long-Term Care in Rural Hospitals in Iowa, South Dakota, and Texas: Second Year Report, March 1979.

In addition, the Center for Health Services Research was the evaluator for the Utah Cost Improvement Project (UCIP), under contract #SSA-PMB-74-386 with the Health Care Financing Administration (HCFA). The final reports for that evaluation are listed below.

Evaluation of an Experiment to Provide Long-Term Care in Rural Hospitals in Utah: Volume I Summary Report, April 1978.

Evaluation of an Experiment to Provide Long-Term Care in Rural Hospitals in Utah: Volume II Technical Report, April 1978.

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